CLIENT INFORMATION : This information is confidential.

Name:_____
(First) (Middle) (Last)

Birth Date:_____/_____/_____ Age: _____ Gender _____

Address:_____
(Street and Number)

_____
(City) (State) (Zip)

Please describe your living situation: _____

Please list any children/ages: _____

Preferred phone: _____ May I leave a message? □ Yes □ No

* E-mail:_____May I email you? □ Yes □ No

* Please note: Email is not a confidential means of communication, and it is best to make emails brief (such as confirming an appointment).

Referred by: _____

Primary Insurance:_____Secondary: _____

Physician:_____ Phone: _____

Psychiatrist:_____ Phone: _____

Emergency contact:_____Phone: _____

Please describe your reasons for seeking therapy: _____

_____

_____

Your specific goals: _____

_____